TOTAL ADMINISTRATIVE SERVICES CORPORATION (TASC)
d/b/a GENESIS EMPLOYEE BENEFITS
FLEXIBLE BENEFITS PLAN
BASIC PLAN DOCUMENT
City of Bloomington

Genesis
Employee Benefits
A TASC Division

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ARTICLE I.
INTRODUCTION

1.1 **Establishment**. The Plan is hereby established, or amended and restated, as of the Effective Date.

1.2 **Purpose**. The purpose of the Plan is to provide Participants with a choice between cash and certain "qualified benefits" as defined in Section 125 of the Code. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code so that Optional Benefits a Participant elects to receive under the Plan will be eligible for exclusion from the Participant's gross income to the fullest extent possible under the Code.

1.3 **HIPAA Privacy and Security Rules**. Portions of this Plan are "covered entities" for purposes of the Privacy Rules and the Security Rules.

1.4 **Gender and Number**. Pronoun references in this Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

ARTICLE II.
DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 **Adoption Agreement** means the separate Adoption Agreement that shall be executed by an Employer adopting the Plan. The Adoption Agreement contains Employer-specific information and the Employer's selections of options under the Plan.

2.2 **Cafeteria Plan Regulations** means any final regulations, or proposed regulations on which employers may rely, issued by the Department of Treasury under Section 125 of the Code.

2.3 **Cash Payment** means the amount received by a Participant described in Article XVII, if applicable.

2.4 **Change in Status** means the situations that permit an Eligible Employee or Participant to make a change in his or her Election mid-Plan Year and include events that:

(a) change an Eligible Employee's or Participant's legal (under applicable state and federal law) marital status,

(b) change the number of an Eligible Employee's or Participant's dependents (as defined in Section 5.4),

(c) change an Eligible Employee's or Participant's employment status, or the employment status of the Participant's Spouse or dependents (as defined in Section 5.4),

(d) cause an Eligible Employee's or Participant's dependent (as defined in Section 5.4) to satisfy or cease to satisfy the eligibility requirements for an Optional Benefit, and

(e) change the place of residence of an Eligible Employee or Participant, or his or her Spouse or dependents (as defined in Section 5.4).

2.5 **Claims Administrator** means Genesis Employee Benefits, Inc., as appointed under Section 6.1(c).

2.6 **Claims Grace Period** means—

(a) **Grace Period**. An eligible expense incurred prior to the fifteenth day of the third calendar month following the close of the Plan Year shall be deemed to have been incurred for purposes of both the preceding Plan Year and the current Plan Year. Such period of time shall be referred to as the "Claims Grace Period."

(b) **Processing of Claims**. Claims incurred during the Claims Grace Period, and submitted prior to the close of the Claims Run-Out Period, shall be first allocated to and reimbursed from the Participant's respective reimbursement-type account for the preceding Plan Year until such reimbursement-type account is exhausted. Thereafter, any such claims shall be allocated to and reimbursed from the Participant's reimbursement-type account for the current Plan Year. Claims incurred during the Claims Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated, there shall be no changes, modifications, or adjustments to the allocation of the account. In accordance with this part (b), a claim incurred during the preceding Plan Year and submitted during the Claims Run-Out Period will be processed subsequent to a previously submitted claim

incurred during the Claims Grace Period, even if the account from the preceding Plan Year is exhausted by reimbursement of the claim incurred during the Claims Grace Period.

(c) **Elections**. No adjustment to a Participant's election for the current Plan Year shall be made or allowed based upon the amount of claims reimbursed from the prior Plan Year's account in accordance with part (b) hereof.

2.7 **Claims Run-Out Period** means the period of time following the end of the Plan Year (or applicable Claims Grace Period) during which claims incurred during such Plan Year (and applicable Claims Grace Period) may be submitted as provided in the Optional Benefit.

2.8 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.9 **Compensation** means the total salary, wages, bonuses, pay for overtime, vacation pay, sick pay, pay for shift differentials, and other cash compensation paid by the Employer to a Participant (without regard to any salary reduction under this Plan or any pre-tax program recognized under the Code), but excluding reimbursed expenses, car expense allowances, credits for benefits under any plan of deferred compensation to which the Employer contributes, and any additional compensation payable in a form other than cash.

2.10 **Covered Individual** means a person, including a Participant, a Dependent of a Participant, a Spouse of a Participant, and any other person, appropriately covered under an Optional Benefit subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and, for governmental Employers, as reflected in the Public Health Services Act, as amended ("PHSA").

2.11 **Dependent** means "Dependent" as defined in each Optional Benefit provision in which such term is used. Dependent is not necessarily the same as a dependent for tax purposes. See the definition of Tax Dependent in Section 2.39.

2.12 **Effective Date** means the date(s) specified in the Adoption Agreement on which the Plan, or Plan amendment and restatement, is effective and applicable to the Eligible Employees and Participants, unless another effective date is specifically provided herein.

2.13 **Election** means the choice of Optional Benefits and means of payment made by the Participant, as described in Article V.

2.14 **ePHI** means PHI maintained or transmitted in electronic media including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.15 **Election Period** means the period of time identified by the Plan Administrator prior to the start of a Plan Year during which a Participant may change his or her Election. For a Participant who enters the Plan other than at the start of a Plan Year, Election Period means the period of time identified by the Plan Administrator prior to the date on which the Eligible Employee begins participation during which an Eligible Employee may make an Election or change a deemed Election.

2.16 **Eligible Employee** means each Employee who has met the eligibility requirements of Section 3.1.

2.17 **Employee** means any person employed by the Employer and on the Employer's W-2 payroll on or after the Effective Date, except that it shall not include:

(a) any self-employed individual as described in Section 401(c) of the Code;

(b) any employee included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan;

(c) any employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States;

(d) any employee who is a leased employee as defined in Section 414(n)(2) of the Code; or

(e) an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; or

(f) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

All employees who are treated as employed by a single employer under subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this Plan. Employee also includes any elected official of the Employer employed by the Employer on or after the Effective Date.

2.18 **Employer** means the Employer named in the Adoption Agreement and any affiliate that, with the consent of the Employer, becomes an Employer by adopting the Plan or any successor business organization that assumes the obligations of the Employer. For non-governmental Employers, "affiliate" means an entity (other than the Employer) which is part of a group of entities which includes the Employer and which constitutes (a) a controlled group of corporations (as defined in Section 414(b) of the Code), (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code), or (c) an affiliated service group (within the meaning of Section 414(m) of the Code).

2.19 **Employer Contribution** means amounts, if any, described in the Adoption Agreement that have not been actually or constructively received by the Participant that are made available to the Participant by the Employer for the purpose of electing Optional Benefits under the Plan.

2.20 **Entry Date** means the date(s) specified by the Employer in the Adoption Agreement as of which Eligible Employees may become Participants in this Plan, provided all necessary forms have been completed.

2.21 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended. Governmental entities, public schools, and some church-related entities and some Indian Tribe operations are not subject to ERISA.

2.22 **Highly Compensated Individual** means individuals who are highly compensated as defined in Section 125(e)(2) of the Code.

2.23 **Highly Compensated Participant** means Participants who are highly compensated as defined in Section 125(e)(1) of the Code.

2.24 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, and regulations thereunder, as amended from time to time.

2.25 **HSA** means a health savings account within the meaning of Section 223 of the Code.

2.26 **Insurer** means any insurance company that has issued a policy through which benefits are made available under this Plan.

2.27 **IRS** means the Internal Revenue Service.

2.28 **Key Employee** means an Employee who is a "Key Employee" as defined in Section 416(i) of the Code. Governmental employers do not have Key Employees.

2.29 **Optional Benefits** means the benefits made available through this Plan as indicated in the Adoption Agreement. To the extent a benefit described in this Basic Plan Document is not an Optional Benefit available under the Plan (as indicated in the Adoption Agreement), the provisions in this Basic Plan Document applicable to such benefit shall be ineffective.

2.30 **PHI** means information that:

(a) is created or received by a health plan, health care provider, or health care clearinghouse;

(b) relates to the past, present and future physical or mental health or condition of an individual (including "genetic information" as that term is defined in the Genetic Information Nondiscrimination Act of 2008); the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

(c) either identifies the individual or reasonably could be used to identify the individual.

PHI includes ePHI.

2.31 **Participant** means an Eligible Employee who participates in the Plan in accordance with Article III and has not ceased to be a Participant under Section 3.4.

2.32 **Plan** means the cafeteria plan and the completed Adoption Agreement as each may be amended from time to time. This Plan shall be known by the name indicated in the Adoption Agreement.

2.33 **Plan Administrator** means the entity determined under Section 6.1.

2.34 **Plan Year** means the twelve-month period commencing on the first day of the month elected in the Adoption Agreement and ending on the last day of the twelfth month following. A "short" Plan Year consists of less than a twelve-month period and must be indicated in the Adoption Agreement.

2.35 **Privacy Rules** means the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.

2.36 **Security Rules** means the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C.

2.37 **Spouse** means an individual who is (a) legally married to a Participant (under applicable state law), and (b) who is treated as a "spouse" under the applicable section of the Code.

2.38 **Summary of Health Information** means "summary health information" as defined in 45 C.F.R. Section 164.504, which generally defines "summary health information" to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving benefits under the Plan from which certain identifiers have been deleted.

2.39 **Tax Dependent** means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility Requirements**. Each Employee shall be eligible to participate in this Plan upon meeting the eligibility requirements as set forth in the Adoption Agreement.

3.2 **Notification to Participants**. The Plan Administrator shall provide each Eligible Employee written notice of the Employee's eligibility to participate in the Plan in sufficient time to enable such Eligible Employee to submit an application for participation in the Plan on or before the applicable Entry Date.

3.3 **Application for Participation.**

(a) **Generally**. In general, unless an Eligible Employee is deemed to have made an Election as provided in Section 5.1, to become a Participant, an Eligible Employee shall execute and deliver to the Plan Administrator, prior to the applicable Entry Date, an application signed by the Eligible Employee in which the Eligible Employee:

(i) applies to participate in the Plan;

(ii) designates the required portion of Compensation for the pre-tax and after-tax (if any) contributions;

(iii) makes a benefit Election; and

(iv) supplies any other pertinent information that the Plan Administrator may reasonably require.

By signing such application or agreement, the Eligible Employee shall be deemed for all purposes to have agreed to participate and to conform to the requirements of the Plan. Such application or agreement may be the same as, or separate from, the application or agreement required to participate in any Optional Benefit under this Plan. Alternatively, or in addition to the forgoing application process, the Plan Administrator may require or permit application of same scope by electronic means.

(b) **Newly Hired**. If provided in the Adoption Agreement, the following special rule for new hires applies under the Plan. An Eligible Employee who is a new hire and who executes and delivers to the Plan Administrator an application to participate within thirty (30) days of being hired shall become a Participant retroactively as of the date of hire pursuant to the Cafeteria Plan Regulations. However, salary reduction contributions to pay for coverage during the period preceding the submission of the application shall be taken prospectively from compensation paid following submission of the application.

3.4 **Termination of Participation**. Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:

(a) the date of the death of the Participant;

(b) the date of termination of the Participant's employment with the Employer;

(c) the date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time; or

(d) the date of termination of the Plan in accordance with Article VII.

Note: This provision applies to *participation* in this Plan. With respect to the Optional Benefits that involve premium payments for other plans sponsored be the Employer, coverage under the underlying plan may extend beyond the date a Participate ceases to be a Participant in this Plan.

In the event the Plan does not learn that a Participant has automatically ceased to be a Participant until a date after the date participation ceased, participation will be terminated retroactively and the Plan shall be entitled to recover any benefits paid after the date participation is terminated. Termination of participation in this Plan shall not prevent a former Participant from continuation coverage, conversion coverage or benefits under the respective Optional Benefit plans if and to the extent provided by such plans.

3.5 **Conditions of Participation**. As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

(a) observe all Plan rules and regulations;

(b) consent to inquiries by the Plan Administrator with respect to any provider of services involved in a claim under this Plan;

(c) submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Plan Administrator may reasonably require; and

(d) repay any overpayments or incorrect payments received under the Plan.

Failure to do so relieves the Plan, Plan Administrator, and Claims Administrator from any and all obligations under this Plan.

3.6 **Participation in Optional Benefit Plans**. In order to elect a specific Optional Benefit provided under this Plan, a Participant must elect that Optional Benefit on such forms as the Plan Administrator may require (unless the benefit is provided to all Participants) and, if the cost of Optional Benefit is not fully paid by the Employer, shall be required to share the cost of the Optional Benefit as provided in Article IV. Further, the Participant must meet any eligibility, participation, etc., requirements applicable to that Optional Benefit in accordance with the terms of the underlying plan through which the Optional Benefit is provided.

ARTICLE IV.
CONTRIBUTIONS

4.1 **Salary Reduction Contributions**. To the extent the cost of an Optional Benefit exceeds the Employer Contribution (if any), a Participant may elect in accordance with the Election procedures described in Article V to receive his or her full Compensation in cash, or to have a portion of such Compensation applied by the Employer toward the Participant's share of the cost of Optional Benefits. If so elected, the Participant's Compensation will be reduced, and an amount equal to the reduction shall be allocated by the Employer to the Optional Benefits designated by the Participant. A Participant's Compensation shall be reduced by pro-rata amounts of the Participant's total salary reduction Election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be as specified in the Adoption Agreement. Notwithstanding the forgoing, if participation in an Optional Benefit extends to the last day of the month in which a Participant's employment terminates, if necessary, additional salary reduction contributions shall be taken from the Participant's final pay check to pay for the coverage provided during the period of time following the date on which the Participant's employment terminates.

4.2 **After-tax Participation**. To the extent a Participant participates in an Optional Benefit that covers a Dependent who is not the Participant's Spouse or Tax Dependent, the coverage for that Dependent shall be purchased on an after-tax basis (in accordance with the Cafeteria Plan Regulations) either by imputing income to the Participant or by the Participant making salary deduction contributions, as determined by the Plan Administrator.

4.3 **Salary Deduction Contributions**. The Employer may require that amounts for which the Participant is responsible, but which cannot be paid with pre-tax dollars through salary reduction described above, be funded with after-tax dollars pursuant to a salary deduction agreement. Such salary deductions shall be made on a periodic basis and relate to a Participant's Compensation after taxes and withholdings have been made.

4.4 **Employer Contribution.** The Employer may make a fixed dollar contribution per Plan Year, or portion of the Plan Year (e.g., month, pay period), per Participant. The amount of the Employer Contribution and any additional restrictions on the use thereof shall be identified in the Adoption Agreement and communicated to the Participants prior to the start of each Plan Year so that they may consider it in making their Elections. The amount of the Employer Contribution may change from year to year as announced by the Employer prior to the Plan Year start and reflected in the Adoption Agreement. No Employer Contribution shall be credited to any Employee during a period of leave of absence, whether authorized or unauthorized, unless required by the Family Medical Leave Act ("FMLA"), if applicable. Employees who are not eligible for participation on the first day of the Plan Year shall have their annual Employer Contribution pro-rated by multiplying the annual available Employer Contribution by a fraction, the numerator of which is the number of months the Employee is eligible for participation for the Plan Year, the denominator which is twelve.

4.5 **Maximum Under the Plan**. Under no circumstances may a Participant's total salary reduction exceed the sum of (a) the cost of benefits paid on a pre-tax basis provided through insurance or insurance types of benefits plus (b) the maximum Election amounts permitted under the reimbursement-type Optional Benefits minus (c) the Employer Contribution, if any.

4.6 **No Trust**. Nothing in this Plan is intended to require the establishment of a trust. The portion of benefits paid under this Plan attributable to Employer Contributions, if any, is paid from the Employer's general assets. The portion of benefits paid under this Plan attributable to Participant contributions including, but not limited to, salary reductions amounts, is paid from the Employer's general assets. To the extent any Optional Benefit made available through this Plan is subject to

ERISA, pursuant to ERISA Technical Release 92-01, such Plan assets are not required to be held in trust. For all other purposes not addressed in ERISA Technical Release 92-01, such amounts retain their character and shall be treated as Plan assets.

4.7 **Insurance Company Refunds**. Any refund provided to the Employer by an insurance company that has issued an insurance contract for any component provided under the Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law. If the Employer is subject to ERISA, the refund will be allocated between the Employer and the Participants in accordance with the then prevailing United States Department of Labor (DOL) guidance. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the component with respect to which the refund was provided, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund of Participant premiums, a premium holiday, an increase in benefits, etc.), as determined by the Plan Administrator in its sole discretion. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

ARTICLE V.
ELECTION OF AVAILABLE BENEFITS

5.1 **Initial Elections**. Unless otherwise specified in the Adoption Agreement, upon initial eligibility, Elections shall be made as follows:

(a) **Affirmative Elections**. With respect to Optional Benefits not providing premium conversions, an affirmative Election to participate is required as part of the application to participate described in 3.3. If the Election Period ends and an Election has not been received by the Plan Administrator, the Eligible Employee will be deemed to have elected not to participate in the above-referenced Optional Benefits involving reimbursement accounts.

(b) **Automatic Elections**. With respect to Optional Benefits providing premium conversions, an Eligible Employee is deemed to have elected to participate and to pay the Participant's share of the cost of such Optional Benefits through salary reduction unless (1) the Eligible Employee specifically elects not to participate with respect to such Optional Benefit(s) and notifies the Plan Administrator in writing on or before the close of the Election Period, or (2) such deemed Election is otherwise prohibited by law.

5.2 **Subsequent Annual Elections**. During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to make a new Election. Such new Election may include the following:

(a) an Eligible Employee who is not participating may elect to begin participating by electing Optional Benefits during the Election Period;

(b) a Participant may terminate participation in the Plan; or

(c) a Participant may elect different Optional Benefits or different levels of Optional Benefits.

An Election must have been made, or deemed to have been made, prior to the start of the Plan Year to which it relates.

5.3 **Failure to Make Annual Election**. Unless otherwise specified in the Adoption Agreement, a Participant who does not make a new Election during the Election Period prior to each Plan Year:

(a) **Affirmative Elections**. With respect to Optional Benefits not providing premium conversions, shall be deemed to have elected not to participate in such Optional Benefits for the upcoming Plan Year.

(b) **Automatic Election**. With respect to Optional Benefits providing premium conversions, shall be deemed, unless prohibited by law, to have elected to pay any portion of the cost for which the Participant is responsible through salary reduction unless (1) the Eligible Employee specifically elects not to participate with respect to such Optional Benefit(s) and notifies the Plan Administrator in writing on or before the close of the Election Period, or (2) such deemed Election is otherwise prohibited by law.

5.4 **Elections Irrevocable**.

For purposes of this Section 5.4, the term "dependent" shall mean (1) a Tax Dependent if the election relates to health benefits, or (2) a Qualifying Individual (as defined in Article X) if the election relates to the Dependent Care Expense Reimbursement Plan.

Unless modified in the Adoption Agreement, an Election becomes effective and shall be irrevocable for the Plan Year or the remainder of the Plan Year except under the following circumstances:

(a) **Change in Status**. A Participant may change or terminate his or her actual or deemed Election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's dependent (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her Election based on that change.

(1) **Loss of Dependent Eligibility**. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance, or insurance-type, coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage only if that coverage becomes actually effective or is increased under the other employer's plan.

(3) **Dependent Care Expense Reimbursement Plan**. With respect to the Dependent Care Expense Reimbursement Plan, a Participant may change or terminate his or her Election only if (i) such a change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (ii) the Election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under the Code.

(4) **Group Term Life Insurance and Disability Income Coverage**. For a Change of Status involving a Participant's legal marital status or the employment status of a Participant's Spouse or dependent (disregarding the requirement that the event cause a loss or gain of eligibility), a Participant may elect either to increase or to decrease group term life insurance or disability income coverage offered under the Plan.

(5) **COBRA Coverage.** If the Participant becomes eligible for COBRA (or similar health plan continuation coverage under state law) under a group health plan sponsored by the Employer, the Participant may increase the Election for that Optional Benefit to pay for such coverage provided the Participant is still eligible under the Plan and still receiving Compensation.

(b) **HIPAA Special Enrollment Rights**. If a Participant, a Participant's Spouse, and/or a Participant's dependent enrolls in a group health plan that is an Optional Benefit of this Plan and subject to the HIPAA special enrollment rights provided by Code § 9801(f), the Participant may make a new election that corresponds with the special enrollment. For purposes of this provision (1) an Election to add previously eligible dependents as a result of the acquisition of a new Spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right; and (2) a HIPAA special enrollment Election attributable to the birth or adoption of a new dependent child may be effective retroactive (up to thirty (30) days), provided it applies to Compensation not yet currently available.

(c) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's dependent child (including a foster child who is a dependent of the Participant), a Participant may: (1) change his or her Election to provide coverage for the dependent child (provided that the Order requires the Participant to provide coverage and subject to the provisions of the underlying group health plan); or (2) change his or her Election to revoke coverage for the dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan.

(d) **Medicare and Medicaid**. If a Participant, a Participant's Spouse, or a Participant's dependent who is enrolled in a health or accident benefit under this Plan (including the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage provided under this Plan (including the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) of the person losing entitlement to Medicare or Medicaid.

(e) **Change in Cost**.

(1) **Automatic Increase or Decrease for Insignificant Cost Changes**. If the cost of an Optional Benefit (other than Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) increases or decreases during a Plan Year by an insignificant amount, then the pre-tax contributions or after-tax contributions (as applicable) under each affected Participant Election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in Participant contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or

decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(2) **Significant Cost Increases**. If the Plan Administrator determines that the cost of an Optional Benefit (other than Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) significantly increases during a Plan Year, the Participant may, on a prospective basis, either: (i) make a corresponding increase in his or her Election; (ii) enroll in another benefit package option providing similar coverage and make a corresponding Election change; or (iii) revoke his or her Election if no other benefit package option providing similar coverage is available. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of an Optional Benefit (other than Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) significantly decreases during a Plan Year: (i) an Eligible Employee or Participant may commence participation in such Optional Benefit; and (ii) the Plan Administrator shall automatically effectuate a prospective decrease in a Participant's Election with respect to such Optional Benefit in accordance with the cost decrease.

(f) **Change in Coverage**.

(1) **Significant Curtailment**. If the Plan Administrator determines that coverage under an Optional Benefit (other than Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) is significantly curtailed during a Plan Year, the Participant may prospectively enroll in another benefit package option providing similar coverage and make a corresponding Election change. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) **Loss of Coverage.** If the Plan Administrator determines that coverage under an Optional Benefit (other than Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) is lost during a Plan Year, the Participant may, on a prospective basis: (i) enroll in another benefit package option providing similar coverage and make a corresponding Election change; or (ii) revoke his or her Election if no other benefit package option providing similar coverage is available. Coverage under an accident or health plan is deemed "lost" only if there is a complete loss of coverage under the benefit package option (e.g., due to elimination of the benefit package option or application of an annual or lifetime maximum) or other fundamental loss of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Addition or Improvement of an Optional Benefit**. If during a Plan Year, the Plan adds a new Optional Benefit or a new benefit package option under the Optional Benefit (other than the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan), or if coverage under an existing Optional Benefit (other than the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) is significantly improved: (i) an affected Participant may prospectively change his/her Election with respect to the newly-added or improved Optional Benefit; and (ii) an Eligible Employee may commence participation in such Optional Benefit. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

(4) **Change Under Another Employer-Sponsored Plan**. A Participant may make a prospective Election change (other than with respect to the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan) that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer), provided (i) the other cafeteria plan or qualified benefits plan permits its participants to make an Election change that would be permitted under the Cafeteria Plan Regulations; or (ii) this Plan permits Participants to make an Election for a Plan Year period of coverage which is different from the plan year period of coverage under the other cafeteria plan or Optional Benefit. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under another employer-sponsored plan.

(5) **Loss of Governmental or Educational Coverage**. A Participant may prospectively change his or her Election to add group health coverage for the Participant or his or her Spouse or dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution including, but not limited to, the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).

(6) **Enrollment in Marketplace Coverage.**

(i) A Participant who has made an Election to pay for Group Medical Benefits may revoke that Election if the following conditions are satisfied:

(A) The Participant either (I) is eligible to enroll in a qualified health plan through a public insurance exchange (the "Marketplace") via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (II) seeks to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(B) The Participant cancels coverage under the Group Medical Benefits in accordance with the requirements of that plan; and

(C) The Participant, and any related individuals who were also enrolled in the Group Medical Benefits, have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which coverage under the Group Medical Benefits was effective (i.e., there is no break in coverage). The Employer may rely on the reasonable representation of the Participant that the requirements of this paragraph (C) are met.

(ii) Unless determined by the IRS not to be available, a Participant who has made an Election to pay for Group Medical Benefits may reduce that Election if the following conditions are satisfied:

(A) The Participant's Spouse and/or dependents either (I) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (II) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(B) The Participant cancels coverage under the Group Medical Benefits for such Spouse and/or dependents in accordance with the requirements of that plan; and

(C) Such Spouse and/or dependents have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which the coverage under the Group Medical Benefits was effective (i.e., there is no break in coverage). The Employer may rely on the reasonable representation of the Participant that the requirements of this paragraph (C) are met.

(g) **Reduction in Hours Without Loss of Eligibility.** A Participant who has made an Election to pay for Group Medical Benefits may revoke that Election if the following conditions are satisfied:

(1) The Participant has been in an employment status under which the Participant was reasonably expected to average at least thirty (30) hours of service per week;

(2) The Participant has experienced a change in employment status such that the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for Group Medical Benefits;

(3) The Participant cancels coverage under the Group Medical Benefits in accordance with the requirements of that plan; and

(4) The Participant, and any related individuals who were also enrolled in the Group Medical Benefits, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Benefits ends. The Employer may rely on the reasonable

representation of the Participant that the requirements of this paragraph (4) are met.

(h) **Family and Medical Leave Act.** A Participant taking a leave governed by the Family and Medical Leave Act of 1993 ("FMLA") may revoke or change an Election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(i) **Special Rule for HSA Contribution Feature**. A Participant may change his or her Election with respect to the HSA Contribution Feature prospectively at least on a monthly basis. A Participant may also revoke his or her Election with respect to the HSA Contribution Feature prospectively if the Participant becomes ineligible to make or have made HSA contributions under the HSA Contribution Feature.

(j) **Other**. The Plan Administrator shall have the discretion to allow a change to or termination of an Election to the extent such change or termination is the result of any other situation informally recognized by the IRS as providing an exception to the general rule that Elections are irrevocable (e.g., corrections of mistakes, changes to meet nondiscrimination requirements, failure to satisfy underwriting).

A Participant entitled to make a new Election under this Section must do so within thirty (30) days of the event. An Employee who is eligible to elect benefits but declined to do so during the initial Election period, or during a subsequent Election period, may file a new Election within thirty (30) days of the occurrence of an event described above, but only if the new Election is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, Elections made to add medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days. All other new Elections shall be effective prospectively immediately following the date the Participant files the new Election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the Election is made unless a subsequent event (described above) allows a further Election change.

5.5 **Rehire and Eligibility Loss**. Termination of employment shall automatically revoke any Election. Former Participants who are rehired:

(a) After thirty (30) days following a termination of employment, shall have two "periods of coverage;" that period prior to the termination of employment and that period following the re-employment of the terminated Employee. Expenses incurred prior to the termination of employment shall be subject to the Election in effect upon termination; while the Employee shall have an opportunity to make a new Election and expenses incurred after re-employment shall be subject to the Election made upon re-employment.

(b) Within thirty (30) days following a termination of employment, shall have the Election in effect prior to the termination of employment reinstated upon re-employment.

5.6 **Benefit Descriptions**. While an Election to receive one or more of the Optional Benefits may be made under this Plan, the benefits themselves may be provided in accordance with Plan documents or contracts which describe the types and amounts of benefits available, the requirements for participation, procedures for submitting claims, and the other terms and conditions of coverage. Such underlying Plan documents or contracts, if any, are incorporated into this Plan by reference.

5.7 **Forfeiture**.

(a) **Entities Subject to ERISA**. Any amounts, whether obtained through salary reduction, salary deduction, Employer Contributions, or otherwise, under this Plan that are Plan assets and which cannot be distributed by the Plan Administrator to cover the cost of Optional Benefits for the applicable Plan Year, shall be forfeited by the Participant (subject to a Participant's limited right, if applicable, to an account carryover to the following Plan Year). The Plan Administrator may use such forfeited amounts to defray the reasonable administrative costs of the portion of the Plan yielding the forfeiture. To the extent forfeited amounts remain, the Plan Administrator shall arrange for the provision of a benefit for a broad cross section of Participants of the same type as the benefit which resulted in the forfeitures. Under no circumstances shall the Plan Administrator establish an outside formal or informal arrangement under which the forfeited amounts are allocated among Participants based (directly or indirectly) on their individual claims experience under the Plan. This forfeiture requirement shall be applied separately for each Optional Benefit and shall only apply with respect to Plan assets.

(b) **Entities Not Subject to ERISA.** Any amounts, whether obtained through salary reduction, salary deduction, Employer Contributions, or otherwise, under this Plan which cannot be distributed by the Plan Administrator to cover the cost of Optional Benefits for the applicable Plan Year, shall be forfeited by the Participant (subject to a Participant's limited right, if applicable, to an account carryover to the following Plan Year). Forfeited amounts, in accordance with the Cafeteria Plan Regulations, may be: (a) retained by the Employer; (b) used to defray the reasonable administrative costs of the Plan; (c) used to reduce required salary reduction amounts for the immediately following Plan Year on a reasonable and uniform basis; and/or (d) returned to the Participants on a reasonable and uniform basis. Under no circumstances shall the Plan Administrator establish an outside formal or informal arrangement under which the forfeited amounts are allocated among Participants based (directly or indirectly) on their individual claims experience under the Plan.

5.8 **Limitations on Benefits**. Benefits shall be limited as determined by the Plan Administrator in accordance with Section 6.16 for the purpose of ensuring compliance with any nondiscrimination requirement applicable to the Plan or an Optional Benefit.

ARTICLE VI.
ADMINISTRATION

6.1 **Plan Administrator.**

(a) The Plan Administrator shall be responsible for the general supervision of the Plan. If the Plan is subject to ERISA, the Plan Administrator shall also be the named fiduciary of the Plan in accordance with Section 402 of ERISA and therefore shall have the discretionary authority to control and manage the operation and administration of the Plan, including but not limited to, the interpretation and application of the terms of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

(b) The Employer shall be the Plan Administrator unless provided otherwise in the Adoption Agreement. The Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator.

(c) The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of this Plan. Where Optional Benefits purchased through this Plan are provided through an insurance company, Health Maintenance Organization ("HMO"), or Dental Maintenance Organization ("DMO"), or similar entity, that entity shall be the Claims Administrator with respect to those benefits. In all other situations, the Plan Administrator shall be the Claims Administrator unless the Plan Administrator contracts with a third party to act on its behalf and that other entity is identified in the Adoption Agreement.

6.2 **Agent for Service of Legal Process**. The agent for service of legal process for the Plan is the Plan Administrator.

6.3 **Allocation of Responsibility for Administration**. The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

6.4 **Rules and Decisions**. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate to fulfill the purposes of the Plan. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or legal counsel.

6.5 **Procedures**. The Plan Administrator may act at a meeting or in writing. The Plan Administrator may adopt by-laws and regulations as it deems desirable for the conduct of the Plan's affairs and as are consistent with the terms of the Plan.

6.6 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

6.7 **Reimbursement-Type Account Balances**. Participants can obtain a statement of their account balances for the reimbursement-type accounts on the Claims Administrator's website: http://www.americasveba.com.

6.8 **Claim for Benefits**. This Section addresses the requirements for claims for reimbursement-type Optional Benefits chosen in the Adoption Agreement and the provisions of general applicability, regardless of whether the Optional Benefit is subject to ERISA. Claims requirements for other Optional Benefits shall be handled in accordance with the governing documents for those Optional Benefits.

A Participant may apply to the Claims Administrator for reimbursement of eligible expenses incurred during such Plan Year (and applicable Claims Grace Period) by submitting a paper claim, or, if provided in the Adoption Agreement, through electronic payment as described below:

(a) **Paper Claims**. A Participant may make a claim by completing a claim form and submitting such form to the Claims Administrator (or its designee) via email, facsimile, mail, or the Claims Administrator's website setting forth at least the following:

(i) the amount, date and nature of the expense, including the identity of the individual who incurred the expense;

(ii) the name of the person or entity to which the expense was paid;

(iii) the Participant's statement that the expense has not been reimbursed and the Participant will not seek reimbursement for the expense; and

(iv) such other information as the Claims Administrator may require.

Such claim form shall be accompanied by such bills, invoices, receipts, explanations of benefits ("EOB") issued by a health plan, or other statements from an independent third party as is necessary to establish that an eligible expense has been incurred and the amount of the expense. The Claims Administrator is entitled to rely on the information provided on the claim form in processing claims under this Plan. Where circumstances beyond the Participant's control prevent submission within the described time frame, notice of a claim with an explanation of the circumstances may be accepted by the Claims Administrator as a timely filing. Claims shall be determined in accordance with Article VI.

Reimbursement shall be made weekly. Claims (including all information substantiating the claim) must be submitted by the deadline established and communicated by the Claims Administrator. Reimbursements shall be made from the Participant's respective reimbursement-type account for eligible expenses incurred during the applicable Plan Year for which the Participant submits the required documentation.

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(b) **Electronic Payment – Medical Expense Reimbursement Plan and Limited Scope Medical Expense Reimbursement Plan**. If selected in the Adoption Agreement, a Participant may receive reimbursement of an eligible expense under the Medical Expense Reimbursement Plan and the Limited Scope Medical Expense Reimbursement Plan (if applicable) by use of an electronic payment card (to the extent made available by the Claims Administrator) at the time the eligible expense is incurred. The use of the electronic payment card shall be subject following conditions:

(1) The electronic payment card may be used only while a Participant is employed by the Employer.

(2) The balance of the electronic payment card shall be limited to the amount in the applicable Participant's reimbursement-type account(s).

(3) A Participant must certify in writing prior to issuance of the electronic payment card that:

(i) the electronic payment card will be used only for eligible expenses that have not been reimbursed under any other plan covering similar benefits; and

(ii) the Participant will not seek reimbursement for any expense paid with the electronic payment card under any other plan covering benefits.

The electronic payment card shall include a statement providing that each use of the card shall constitute a reaffirmation of the certification.

(4) For eligible expenses, the electronic payment card may be used only at merchants who are health care providers (e.g., doctor's office, hospital, pharmacy, etc.) or other merchants identified in applicable IRS guidance.

(5) Each time the electronic payment card is used, a Participant shall obtain and retain a third party statement from the health care provider containing the information necessary to substantiate that the expense paid by the card was an eligible expense.

(6) Claims shall be substantiated in one of the following manners:

(i) The Participant shall provide, upon request by the Claims Administrator (or its designee), the third party statement with respect to the claim.

(ii) For eligible expenses, the payment was made to a merchant who is a health care provider and it matches a specific co-payment the Participant has under a group medical or group dental plan sponsored by the Employer or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment.

(iii) For eligible expenses, the payment was made to a merchant who is a health care provider and is for an expense with the same amount, duration, and health care provider as a previously approved expense under this Plan.

(iv) For eligible expenses, the payment was made to a merchant who is a health care provider and the electronic claim file with respect to the

expense is accompanied by an electronic or written confirmation from the health care provider that verifies the nature and amount of the expense and that the expense is an eligible expense.

(v) For eligible expenses, the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(7) Claims for over-the-counter drugs and medicines (other than insulin) shall be substantiated in accordance with IRS Notice 2011-5 and/or other applicable IRS guidance.

(8) A Participant shall repay the Plan for a payment with respect to any claim not substantiated (and therefore not eligible for reimbursement) as required above. The Plan shall handle unsubstantiated claims as required under the Code and applicable regulations.

(9) The use of an electronic payment card does not constitute a "claim" under the claims procedures.

(c) **Electronic Payment – Dependent Care Expense Reimbursement Plan**. If selected in the Adoption Agreement, a Participant may receive reimbursement of an eligible expense under the Dependent Care Expense Reimbursement Plan (if applicable) by use of an electronic payment card (to the extent made available by the Claims Administrator) at the time the eligible expense is incurred. The use of the electronic payment card shall be subject following conditions:

(1) At the beginning of each Plan Year or, if later, upon the Participant's Entry Date, the Participant must pay the initial eligible expense to the dependent care provider and submit a paper claim to the Plan for such expense.

(2) Upon substantiation by the Claims Administrator of the initial eligible expense, the Plan will make available through the electronic payment card an amount equal to the lesser of: (i) the amount of the approved claim, or (ii) the contributions made by or on behalf of the Participant to the Dependent Care Expense Reimbursement Plan for the Pan Year to date.

(3) The electronic payment card may then be used to pay for subsequently incurred eligible dependent care expenses.

(4) The amount available through the electronic payment card may be increased only as additional dependent care expenses are incurred and substantiated via submission of a paper claim, except as provided in paragraph (5) below. In no case will the amount available through the electronic payment card exceed the contributions made by or on behalf of the Participant to the Dependent Care Expense Reimbursement Plan for the Plan Year to date minus the amount of expenses previously reimbursed during such Plan Year (whether such reimbursement was made in cash or by crediting the electronic payment card).

(5) Dependent care expenses may be automatically substantiated without submission of a paper claim only as provided in this paragraph (5). If (i) an electronic payment card transaction collects information that matches information for a previously approved paper claim with respect to the dependent

care provider, and (ii) the amount of the electronic payment card transaction is equal to or less than the previously approved paper claim, then the claim paid via the electronic payment card is substantiated without further review. In such instances, the balance of the electronic payment card may be increased with respect to the automatically substantiated claim once the expense paid through the electronic payment card has been incurred.

Example: If a Participant uses an electronic payment card to pay a day care provider on the first day of the week for the care to be provided during that week, and the claim is automatically substantiated as provided above, the balance of the electronic payment card may be increased with respect to such claim at the end of the week.

(d) **Automatic Reimbursement of Recurring Claims – Dependent Care Expense Reimbursement Plan and Individual Premium Feature.** The Plan provides for automatic reimbursements of certain eligible expenses under the Dependent Care Expense Reimbursement Plan. The Plan also provides for automatic reimbursements of eligible expenses under the Individual Premium Feature if the Claims Administrator reimburses claims under that portion of the Plan. To receive automatic reimbursements as provided herein, the Participant must complete and return a form to the Plan Administrator, or its designee, electing to do so. A Participant must submit the first claim incurred during a particular Plan Year pursuant to the standard paper claim procedures described above. Subsequent to reimbursement of that claim, the Claims Administrator will automatically reimburse an amount equal to the amount of the first claim at the appropriate payment interval without submission of an additional paper claim. For purposes of this provision, the appropriate payment interval shall be the time period reflected in the first claim for which the services or coverage was provided (e.g., weekly, monthly, quarterly, etc.). Notwithstanding anything herein to the contrary, reimbursements for recurring claims shall be made only after the eligible expense was incurred (i.e., after the services have been provided). In the event the amount of the eligible expense or the identity of the service provider or insurance carrier changes, the Participant must submit a paper claim with respect to the new amount or service provider/insurance carrier.

6.9 **Determination of Benefits**. This Section addresses the claims determination and appeal procedures for reimbursement-type Optional Benefits chosen in the Adoption Agreement, and the provisions of general applicability, regardless of whether any portion of this Plan is subject to ERISA. Claims determination and appeal procedures for other Optional Benefits shall be handled in accordance with the governing documents for those Optional Benefits.

(a) **Initial Determination**. The Plan Administrator, or Plan Administrator's designee, shall notify a person within thirty (30) days of receipt of a written claim for benefits of that person's eligibility or non-eligibility for benefits under the Plan. If it is determined that a person is not eligible for benefits or for full benefits, the notice shall set forth:

(1) the specific reasons for the denial;

(2) a specific reference to the provision of the Plan on which the denial is based;

(3) a description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is needed; and

(4) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have the claim reviewed.

If the Plan Administrator, or Plan Administrator's designee, determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator, or Plan Administrator's designee, shall notify the Participant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional fifteen (15) days.

(b) **Appeals.** If a Participant is determined by the Plan Administrator, or Plan Administrator's designee, not to be eligible for benefits, or if the Participant believes that he or she is entitled to greater or different benefits, the Participant shall have the opportunity to have the claim reviewed by the Plan Administrator, or Plan Administrator's designee, by filing a petition an appeal within one hundred eighty (180) days after receipt by the Participant of the notice issued by the Plan Administrator, or the or Plan Administrator's designee. The appeal shall state the specific reasons the Participant believes he or she is entitled to benefits or greater or different benefits.

Within sixty (60) days after receipt of the appeal, the Plan Administrator, or Plan Administrator's designee, shall afford the Participant (and the Participant's counsel, if any) an opportunity to present the Participant's position to the Plan Administrator, or Plan Administrator's designee, orally or in writing, and the Participant (or the Participant's counsel) shall have the right to review the pertinent documents.

(c) **Decision on Appeal.** The Plan Administrator, or Plan Administrator's designee, shall notify the Participant of its decision on appeal in writing within said sixty (60) day period of said decision. If it is determined that a person is not eligible for benefits or for full benefits the notice shall set forth:

(i) the specific reasons for the denial;

(ii) a specific reference to the provision of the Plan on which the denial is based;

(iii) a statement of your right to review (on request and at no charge) relevant documents and other information;

(iv) if the Plan Administrator relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

(v) if the entity is subject to ERISA, a statement of your right to bring suit under ERISA § 502(a).

In the event of the death of a Participant, the same procedure shall be applicable to the Participant's beneficiaries.

6.10 **Authorization of Benefit Payments**. The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's assets, pursuant to the provisions of the Plan, and shall warrant at the time the directions are provided that all such directions are in accordance with the Plan.

6.11 **Overpayments.** If a payment for benefits is made by the Plan in excess of the benefit to which a Covered Individual is entitled under the Plan, the Plan shall have the right to recover such

overpayment from the payee. Repayment of an overpayment is a condition of participation in the Plan.

6.12 **Inability to Locate Payee.**

(a) **Entities Subject to ERISA:** If benefits are due under this Plan and the Plan Administrator is unable, after reasonable attempts to do so, to locate the Participant to whom such benefits are payable, such benefits shall be forfeited in accordance with Section 5.7. For purposes of the foregoing, the Plan Administrator shall be deemed to be unable to locate a Participant if a check issued for benefits payable under the Plan has been sent to the payee's last known address and has not been cashed within twelve (12) months of its date of issuance.

(b) **Entities Not Subject to ERISA:** If benefits are due under this Plan and the Plan Administrator is unable, after reasonable attempts to do so, to locate the Participant to whom such benefits are payable, such benefits shall be handled in accordance with applicable state law regarding unclaimed property or escheat. For purposes of the foregoing, the Plan Administrator shall be deemed to be unable to locate a Participant if a check issued for benefits payable under the Plan has been sent to the payee's last known address and has not been cashed within three (3) years of its date of issuance.

6.13 **Facility of Payment.** Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage their financial affairs, the Plan Administrator may request the Employer to make payments to such person, or the Plan Administrator may request the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit, or installment, in accordance with the provisions of this Section, shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan. To the extent the Plan is not subject to ERISA, the same procedure shall be followed.

6.14 **Other Powers and Duties of the Administrator**. The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, except to the extent the eligibility determinations are governed by an insurance contract, and to determine all questions arising in the administration and application of the Plan, except to the extent such eligibility determinations are governed by an insurance contract;

(b) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) to appoint individuals to assist in the administration of the Plan and any other agents the Plan Administrator deems advisable, including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.

6.15 **Indemnification**. To the maximum extent allowed by, and in accordance with applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.

6.16 **Changes by the Plan Administrator**. If the Plan Administrator determines before or during any Plan Year that the Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Code or any other applicable law (including any limitation on benefits provided to Key Employees), the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of Elections by Highly Compensated Participants or Key Employees with or without consent of such Employees and/or a re-characterization within the Plan Year of benefits provided under the Plan as taxable income with or without consent of such Employees.

6.17 **Plan Interpretation.** This Plan will be administered in accordance with its terms. The Plan Administrator and/or a fiduciary acting as a fiduciary with respect to this Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including, but not limited to, the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Covered Individuals, claimants, and all interested parties.

ARTICLE VII.
PLAN AMENDMENT AND TERMINATION

7.1 **Employer Amendments**. The Employer reserves the right to amend the Plan, or any portion of the Plan, at any time. The Employer expressly may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the law. Such amendments shall not affect any right to benefits that accrued prior to such amendment. Such amendment shall be made in writing and in accordance with Section 8.4.

7.2 **Employer's Right to Terminate**. Although the Employer expects the Plan to be maintained for an indefinite time, the Employer reserves the right to terminate the Plan or any portion of the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the resolution of such successor's managing body. Such termination shall not affect any right to benefits that accrued prior to any termination. Such action shall be taken in writing and in accordance with Section 8.4.

7.3 **Amendments by Claims Administrator**. Claims Administrator reserves the right to amend the Plan from time to time. Although it is intended that this power of amendment will be used primarily to ensure compliance with the provisions of ERISA (if applicable), the Code, and/or other applicable law, this power of amendment may be used for any purpose deemed appropriate by Claims Administrator. Unless required by law, such amendments shall not affect any right to benefits that accrued prior to such amendments. Such amendment shall be accomplished by providing written notice to the Employer.

ARTICLE VIII.
GENERAL PROVISIONS

8.1 **Plan Not a Contract of Employment**. The Plan is not an employment contract and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

8.2 **No Right to Employer's Assets**. No Employee, Participant or beneficiary thereof shall have any right to, or interest in, any assets of the Employer upon termination of employment, or otherwise except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Employee, Participant or beneficiary thereof. In addition, the Claims Administrator shall not be liable in any manner for such payments.

8.3 **Non-Alienation of Benefits**. Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer, Plan Administrator and/or Claims Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

8.4 **Action by Employer**. Whenever the Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Employer or such representatives of the Employer as the managing body may designate.

8.5 **No Guarantee of Tax Consequences**. Notwithstanding any provision in this Plan to the contrary, neither this Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

8.6 **Indemnification of Employer by Participants**. To the maximum extent allowed by, and in accordance with, applicable law, if any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

8.7 **Benefits Provided Through Third Parties**. In the case of any Optional Benefit provided through a third party (e.g., an insurance company pursuant to a contract or policy with that third party), if there is any conflict or inconsistency between the description of benefits contained in this Plan and the contract or policy, the terms of the contract or policy shall control, unless prohibited by applicable law or specifically addressed in this Plan.

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8.8 **Mistakes and Errors**. It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

8.9 **Limitation on Liability**. The Employer does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the Insurer or other entity that is required to provide such benefits under such policy or contract.

8.10 **Governing Law**. This Plan shall be construed and enforced according to the laws of the state identified in the Adoption Agreement except to the extent preempted by federal law.

8.11 **Family and Medical Leave Act of 1993**. Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

8.12 **Uniformed Services Employment and Reemployment Rights Act of 1994**. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), and the Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA and such policies shall be incorporated herein by reference.

8.13 **Genetic Information Nondiscrimination Act of 2008**. Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008 ("GINA").

ARTICLE IX.
GROUP MEDICAL BENEFITS

9.1 **Purpose**. The purpose of this Article is to provide for the pre-tax payment opportunity for Group Medical Benefits under this Plan as an Optional Benefit. The Employer provides Group Medical Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

9.2 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

9.3 **Definitions**.

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Medical Benefits.

(b) **Group Medical Benefits** means the medical coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(c) **HMO** means a health maintenance organization authorized to do business in the state in which it operates with which an agreement has been entered for the purpose of providing benefits under the Plan.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Insurance Contract** means (1) any insurance contract secured from an insurance company or HMO authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan; or (2) a self-insured plan administered by a third party.

(f) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, including continuation coverage under the Insurance Contract.

9.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contract. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan.

9.5 **Payments**. The Plan Administrator shall make Insurance Premium payments for the Group Medical Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Medical Benefits. To the extent a Dependent is provided coverage under

the Group Medical Benefits and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2.

9.6 **Nondiscrimination**. To the extent the Group Medical Benefits are subject to Section 105(h) of the Code or Section 2716 of the Public Health Services Act, they shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

9.7 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Group Medical Benefits to the extent required by applicable law.

9.8 **Continuation of Coverage**. Continued coverage shall be provided under the Group Medical Benefits as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference. There shall also be compliance with state laws concerning continuation of coverage to the extent not preempted by federal law.

9.9 **HIPAA.** The Group Medical Benefits shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract. In addition, the Group Medical Benefits shall comply with the portability requirements under HIPAA.

ARTICLE X.
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

10.1 **Purpose**. The purpose of this Article is to provide Participants with the opportunity to be reimbursed for eligible Dependent Care Expenses under this Plan as an Optional Benefit under the Plan. This Article is intended to qualify as a "dependent care assistance program" under Section 129 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 129(a) of the Code. This Dependent Care Expense Reimbursement Plan is not subject to ERISA.

10.2 **Separate Written Plan**. For purposes of Section 129 of the Code, this Article shall constitute a separate written plan providing reimbursement of certain Dependent Care Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

10.3 **Definitions**.

(a) **Claims Run-Out Period** means the period beginning on the first day following the close of the Plan Year or, if applicable, the Claims Grace Period and ending on the date specified in the Adoption Agreement.

(b) **Dependent Care Account ("DC Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

(c) **Dependent Care Center** shall have the meaning given such term in Sections 21(b)(2)(C) and 21(b)(2)(D) of the Code: a facility that (1) complies with all applicable laws and regulations of the state and town, city or village in which it is located; (2) provides care for more than six individuals (other than individuals who reside at the facility); and (3) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(d) **Dependent Care Expenses** means amounts paid by the Participant for services that would be considered employment-related expenses under Section 21(b)(2) of the Code, any applicable proposed or final regulations issued thereunder, or any guidance issued by the IRS interpreting or applying any of the foregoing. Employment-related expenses for purposes of this Plan include expenses incurred to enable a Participant to be Gainfully Employed during any period for which there are one or more Qualifying Individuals with respect to the Participant for (1) household services, and (2) care of a Qualifying Individual. However, employment-related expenses which are incurred for services outside the Participant's household shall be considered Dependent Care Expenses only if incurred for the care of a Qualifying Individual described in Section 10.3(i) below or a Qualifying Individual not described in Section 10.3(i) below who regularly spends at least eight (8) hours each day in the Participant's household. Dependent Care Expenses do not include expenses which are incurred for services provided by a Dependent Care Center if such center does not comply with all applicable laws and regulations of the applicable State or other unit of local government which regulates the center. In addition, Dependent Care Expenses shall not include any amounts paid to an individual who:

(1) is a child of such Participant (within the meaning of Section 152(f)(1) of the Code) who is under the age of nineteen (19) at the close of such taxable year;

(2) with respect to whom, for such taxable year, a deduction is allowable under Section 151(c) of the Code (relating to personal exemptions for dependents) to such Participant or the Spouse of such Participant;

(3) is the Spouse of the Participant at any time during the taxable year; or

(4) is the parent of the Participant's child who is a Qualifying Individual.

(e) **Earned Income** shall have the meaning given such term in Section 32(c)(2) of the Code (which refers to wages, salaries, tips and other Employee Compensation as well as net earnings from self-employment), but shall not include any amounts reimbursed by the Employer under this portion of the Plan. Further, if a Participant's Spouse is a Student or incapable of caring for himself or herself, the provisions of Section 21(d)(2) of the Code shall apply in determining the Earned Income of that Spouse. Generally, this Section provides that a Spouse of a Participant shall be deemed to have Earned Income of not less than $250 per month if there is one Qualifying Individual with respect to the Participant or $500 per month if there are two or more Qualifying Individuals with respect to the Participant.

(f) **Gainfully Employed** means the earning of income for services performed or the period of active search for gainful employment. Nominal reimbursement for volunteer work is not considered gainful employment.

(g) **Highly Compensated Employees** means Employees who are "highly compensated" as defined in Section 414(q) of the Code.

(h) **Non-Highly Compensated Participants** means Employees who are not Highly Compensated Employees.

(i) **Qualifying Individual** means a person for whom expenses can be submitted for reimbursement.

1) A Qualifying Individual is:

i) the Participant's "qualifying child" under Section 152 of the Code who is under age thirteen (13);

ii) the Participant's "qualifying child" under Section 152 of the Code (determined without regard to Sections 152(b)(1) and (b)(2) of the Code) who is mentally or physically unable to care for himself or herself;

iii) the Participant's "qualifying relative" under Section 152 of the Code (determined without regard to Sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code) who: (1) is mentally or physically unable to care for himself or herself; and (2) has the same principal place of abode as the Participant for at least one-half of the year; or

iv) the Participant's Spouse who: (1) is mentally or physically unable to care for himself or herself; and (2) has the same principal place of abode as the Participant for at least one-half of the year

2) With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are

involved, there two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

i) **Divorced or Separated Parents, or Parents Living Apart.** If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is the parent identified in Section 152(e) of the Code (i.e., generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year).

ii) **Two or More Persons Claiming a Child as a Qualifying Individual.** If the special rule described above regarding divorce, etc. does not apply, the special tie-breaker rules of Section 152(c)(4) of the Code may apply. If an individual is a qualifying child (as defined in Section 152 of the Code) with respect to more than one person, then:

a. If both persons are the individual's parents and they file a joint federal income tax return, the child is the Qualifying Individual of both parents.

b. If both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resided for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

c. If one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent). This is the one

person that is entitled to treat the child as a Qualifying Individual.

d. If neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

(j) **Student** shall have the meaning provided in Section 21(e)(7) of the Code which means an individual who during each of five (5) calendar months during the taxable year is a full time student at an educational organization which normally maintains a regular facility and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on as provided in Sections 21(e)(8) and 170(b)(1)(A)(ii) of the Code.

10.4 **Dependent Care Account**. The DC Account will be credited as of each date contributions are made pursuant to Article IV with a pro-rated portion of the Participant's Election for the Plan Year. A Participant's DC Account will be decreased from time to time in the amount of payments made to the Participant for eligible Dependent Care Expenses incurred during the Plan Year.

10.5 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

10.6 **Incurred Expenses**. To be reimbursable, an eligible Dependent Care Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Dependent Care Expense, not when the service is billed or paid. Reimbursement shall not be made for future or projected expenses.

10.7 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Section 6.8(a) from the Participant's DC Account for eligible Dependent Care Expenses incurred during the applicable Plan Year for which the Participant submits the documentation required under Article VI. In no case shall a payment be made which exceeds the balance in the Participant's DC Account at the time reimbursement is processed. Claims for reimbursement with respect to a Plan Year must be submitted prior to the close of the Claims Run-Out Period for such Plan Year.

If a claim for reimbursement exceeds the available balance in the Participant's DC Account, the excess part of the claim will be carried over and paid as the Participant's DC Account becomes adequate. Under no circumstances (a) will any balance remaining in a Participant's DC Account at the end of the Plan Year be carried over to the next Plan Year, or (b) will an otherwise eligible Dependent Care Expense be carried over to the next Plan Year.

10.8 **Maximum Reimbursement**. The maximum reimbursement which a Participant may receive in a tax year under this portion of the Plan shall be the lesser of:

(a) the Participant's Earned Income for the tax year;

(b) the actual or deemed Earned Income of the Participant's Spouse for the tax year; or

(c) $5,000 (or in the case of a Participant who is married and filing a separate income tax return from his or her Spouse, $2,500).

This maximum includes the Employer Contribution, if any, DC Account forfeitures and the Participant's salary reduction. If a Participant is married and the Spouse of the Participant also participates in a dependent care program under Section 129 of the Code, the combined reimbursements may not exceed the limits described above for the tax year. It shall be the Participant's responsibility to monitor the combined reimbursements.

10.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan during a Plan Year, no further contributions will be credited to the DC Account. A Participant's right to obtain reimbursements after participation has terminated shall be as provided in the Adoption Agreement.

10.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Dependent Care Expense which (a) would have been reimbursable out of the Participant's DC Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's DC Account shall be forfeited in accordance with Section 5.7.

10.11 **Nondiscrimination.** Not more than twenty-five percent (25%) of the amounts paid or incurred by the Employer for Dependent Care Expenses during the Plan Year shall be provided to Participants who are shareholders or owners (or their Spouses or Tax Dependents) of more than five percent (5%) of the stock or of the capital or profit interest in the Employer.

This portion of the Plan shall not discriminate in favor of Highly Compensated Employees or their Dependents with respect to eligibility, contributions or benefits. The average eligible Dependent Care Expenses paid to Non-Highly Compensated Employees shall be at least fifty-five (55%) of the average eligible Dependent Care Expenses paid to Highly Compensated Employees. If benefits are provided through salary reduction agreements, Employees with annual compensation less than $25,000 may be excluded. If the Plan Administrator determines that the Plan is or will be discriminatory, the Plan Administrator may take any action permitted by law to avoid such result in accordance with Section 6.16. If this portion of the Plan fails any applicable nondiscrimination requirements, Highly Compensated Employees shall have taxable income imputed to the extent required by law.

10.12 **DC Account Forfeiture**. Amounts attributed to a Participant's DC Account for any Plan Year shall be used only to reimburse the Participant for eligible Dependent Care Expenses incurred during such Plan Year. Any balance remaining in a Participant's DC Account for a Plan Year shall be forfeited following the end of the Claim Run-Out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

10.13 **Dependent Care Limitations.**

(a) Reimbursement or payment of eligible Dependent Care Expenses shall be made to the Participant only in the event and to the extent that such reimbursement or payment is:

(1) not otherwise provided under any insurance policy, whether the premium on such policy is paid by the Employer or an individual, and (2) not provided for or reimbursable under any other plan or policy.

(b) Other limitations, if any, shall be set forth in the Adoption Agreement.

10.14 **Reporting and Disclosure**. Each Participant must be furnished with a written statement showing the amounts paid under this portion of the Plan by an Employer on behalf of the Participant for a calendar year. The statement must be furnished before January 31st of the following year. If the actual amount paid is not known by this deadline, the Employer may report a reasonable estimate of the amounts paid under this portion of the Plan.

ARTICLE XI.
MEDICAL EXPENSE REIMBURSEMENT PLAN

11.1 **Purpose**. The purpose of this Article is to provide Participants with the opportunity to be reimbursed for certain eligible Medical Expenses as an Optional Benefit under the Plan. This Article is intended to qualify as a self-insured medical reimbursement plan under Section 105 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 105(b) of the Code.

11.2 **Separate Written Plan**. For purposes of Section 105 of the Code, this Article shall constitute a separate written plan providing for the reimbursement of certain Medical Expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

11.3 **Definitions**.

(a) **Claims Run-Out Period** means the period beginning on the first day following the close of the Plan Year or, if applicable, the Claims Grace Period and ending on the date specified in the Adoption Agreement.

(b) **Dependent** means, unless otherwise specified in the Adoption Agreement, Tax Dependent.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Medical Expense** means, unless otherwise limited in the Adoption Agreement, an expense incurred during the applicable Plan Year by a Participant, Spouse, or Dependent for medical care as defined in Section 213 of the Code, excluding premiums for health coverage and long-term care coverage. Medical care generally refers to the diagnosis, cure, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. Also included, are reasonable transportation expenses for and essential to medical care. If "Medical Expense" includes over-the-counter drugs and medicines, such expenses shall constitute Medical Expenses only to the extent allowed by Section 106(f) of the Code.

(e) **Medical Expense Account ("ME Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

11.4 **Medical Expense Account**. The ME Account will be credited with the amount elected by the Participant and the amount of the carryover, if any, at the beginning of the Plan Year. A Participant's ME Account will be decreased from time to time in the amount of payments made to the Participant for eligible Medical Expenses incurred during the Plan Year and the Claims Grace Period, if applicable.

11.5 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

11.6 **Incurred Expenses**. To be reimbursable, an eligible Medical Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed or the Claims Grace Period related to such Plan Year, if applicable. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Medical Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses. Notwithstanding the foregoing, pursuant to and in

accordance with the Cafeteria Plan Regulations, the Plan may reimburse Medical Expenses for orthodontia care in advance.

11.7 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Section 6.8 from the Participant's ME Account for eligible Medical Expenses incurred during the applicable Plan Year and the Claims Grace Period, if applicable, for which the Participant submits the documentation required under Article VI. An amount up to the sum of the Participant's Election and the carryover, if any, and reduced as of any particular time for prior reimbursements for the same Plan Year, and the Claims Grace Period, if applicable, shall be available for reimbursement at all times during the Plan Year, and the Claims Grace Period, if applicable. Claims for reimbursement within a Plan Year, and Claims Grace Period, if applicable, must be submitted prior to the close of the Claims Run-Out Period for such Plan Year and the Claims Grace Period, if applicable.

In no case shall a payment be made which exceeds the balance in the Participant's ME Account at the time reimbursement is processed. If a claim for reimbursement exceeds the balance in the Participant's ME Account, the excess part of the claim will be denied. Except as provided in Section 11.12(b), under no circumstances (a) will any balance remaining in a Participant's ME Account at the end of the Plan Year, and the Claims Grace Period, if applicable, be carried over to the next Plan Year, or (b) will an otherwise eligible Medical Expense be carried over to the next Plan Year.

NOTE: In accordance with IRS Notice 2002-45, if the Employer sponsors a health reimbursement arrangement ("HRA") plan, a Medical Expense that is also reimbursable under the HRA plan must typically be reimbursed first from the HRA plan. However, if the HRA provides that it does not reimburse such expenses until the Participant's ME Account is exhausted (i.e., that it is secondary to the Medical Expense Reimbursement Plan), then an eligible Medical Expense may be reimbursed from the Participant's ME Account prior to exhaustion of the Participant's HRA account. In either case, once the Participant's account balance under the primary plan has been exhausted, then the eligible Medical Expense, or any portion of the eligible Medical Expense that has not been reimbursed by the primary plan, may be reimbursed by the other plan.

11.8 **Maximum Reimbursement.** The maximum reimbursement a Participant may receive for a Plan Year under this portion of the Plan shall be the amount indicated in the Adoption Agreement. The maximum reimbursement amount applies to the Participant, Spouse, and Dependent children on an aggregate basis, not an individual basis. For Plan Years that are less than 12 months, unless indicated otherwise in the Adoption Agreement, this maximum shall be pro-rated by multiplying the applicable maximum by a fraction with a numerator of the number of months in the short Plan Year and with a denominator of 12. For Participants beginning participation in the Plan mid-Plan Year, unless indicated otherwise in the Adoption Agreement, this maximum shall be pro-rated by multiplying the applicable maximum by a fraction with a numerator of the number of complete calendar months remaining in the Plan Year at the time the Participant begins participation and with a denominator of 12. Notwithstanding the foregoing, salary reduction contributions to this portion of the Plan shall not exceed any maximum imposed under applicable law.

11.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan, coverage shall cease (which means that reimbursements shall cease) unless benefits under the Plan are continued as provided in Section 11.14, if applicable. A Participant's right to obtain reimbursements after participation has terminated shall be as provided in the Adoption Agreement.

11.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Medical Expense (a) which would have been reimbursable out of the Participant's ME Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability for the expense, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's ME Account shall be forfeited in accordance with Section 5.7.

11.11 **Nondiscrimination**. This portion of the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such result as provided in Section 6.16. If the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.

11.12 **ME Account Forfeiture**

(a) **ME Account Claims Grace Period**. If selected in the Adoption Agreement, the Claims Grace Period shall apply to this Optional Benefit.

(b) **ME Account Carryover.** If selected in the Adoption Agreement, a limited carryover of ME Account balances from Plan Year to Plan Year will be provided in accordance with the following conditions and restrictions:

(1) The amount that may be carried over is limited to the lesser of (i) the amount specified in the Adoption Agreement, or (ii) the balance of the Participant's ME Account. The balance of a Participant's ME Account shall be determined upon expiration of the Claims Run-out Period.

(2) Notwithstanding the requirement referenced in paragraphs (1) above, the balance of the Participant's ME Account as of midnight on the last day of the Plan Year, up to the amount specified in paragraph (1) above, shall be carried over and available to reimburse Medical Expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the Claim Run-out Period (including allocating claims between the Participant's carryover balance and the Participant's election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

(3) In general, a carryover made in accordance herewith shall occur within the Medical Expense Reimbursement Plan. However, if the Plan includes a Limited Scope Medical Expense Reimbursement Plan, a Participant entitled to an ME Account carryover in accordance herewith shall receive the carryover to a Limited Scope ME Account if: (i) the participant enrolls in the Limited Scope Medical Expense Reimbursement Plan for the following Plan Year, or (ii) the Participant directs the Plan Administrator, by no later than the last day of the Plan Year from which the carryover is to be made and in accordance with procedures adopted by the Plan Administrator, to make the carryover to the Limited Scope Medical Expense Reimbursement Plan.

(4) In general, a carryover made in accordance herewith shall occur automatically. However, a Participant entitled to an ME Account carryover in accordance herewith may elect, by no later than the last day of the Plan Year from which the carryover is to be made and in accordance with procedures adopted by the Plan Administrator, to waive the carryover.

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(5) Unless otherwise required under applicable law (including regulatory guidance), a carryover of an ME Account balance shall be available only to individuals who are eligible to make elections under the Medical Expense Reimbursement Plan as of the first day of the Plan Year to which the carryover will be made (regardless of whether the individual actually elects to participate).

(c) **ME Account Claims Run-Out Period**. Except as otherwise provided herein, (1) amounts attributed to a Participant's ME Account for any Plan Year shall be used only to reimburse the Participant for eligible Medical Expenses incurred during such Plan Year, and (2) any balance remaining in a Participant's ME Account for a Plan Year shall be forfeited following the end of Claims Run-Out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

11.13 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Medical Expense Reimbursement Plan to the extent required by applicable law.

11.14 **Continuation of Coverage**. Continued coverage shall be provided under the Medical Expense Reimbursement Plan as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference.

11.15 **HIPAA**. The Medical Expense Reimbursement Plan shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in Article XVIII.

11.16 **Further Limitations on Benefits**.

(a) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or the Participant, the Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

(d) A Participant in the Plan may not participate under this Article and contribute to a health savings account ("HSA") within the meaning of Section 223 of the Code.

(e) Other limitations, if any, shall be set forth in the Adoption Agreement.

11.17 **Patient Protection and Affordable Care Act.** The Medical Expense Reimbursement Plan is intended to be an excepted benefit under HIPAA because:

(a) all Participants of this Optional Benefit are eligible for Group Medical Benefits, and

(b) the maximum reimbursement available does not exceed the greater of (1) two times the Participant's salary reduction election or (2) the Participant's salary reduction election plus $500.

Accordingly, certain mandates of the Patient Protection and Affordable Care Act, as amended, including the preventative care mandate, do not apply to the Medical Expense Reimbursement Plan.

ARTICLE XII.
GROUP DENTAL BENEFITS

12.1 **Purpose**. The purpose of this Article is to provide for the pre-tax payment opportunity for Group Dental Benefits under this Plan as an Optional Benefit. The Employer provides Group Dental Benefits through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

12.2 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

12.3 **Definitions.**

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Dental Benefits.

(b) **DMO** means a dental maintenance organization authorized to do business in the state in which an agreement has been entered for the purpose of providing benefits under this portion of the Plan.

(c) **Group Dental Benefits** means the dental coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(d) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(e) **Insurance Contract** means (1) any insurance contract secured from an insurance company or DMO authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan; or (2) a self-insured plan administered by a third party.

(f) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, including continuation coverage under the Insurance Contract.

12.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contracts. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan.

12.5 **Payments**. The Plan Administrator shall make Insurance Premium payments for the Group Dental Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Dental Benefits. To the extent a Dependent is provided coverage under the Group Dental Benefits and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2.

12.6 **Nondiscrimination**. To the extent this portion of the Plan is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16. If this portion of the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.

12.7 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Group Dental Benefits to the extent required by applicable law.

12.8 **Continuation of Coverage**. Continued coverage shall be provided under the Group Dental Benefits as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference. There shall also be compliance with state laws concerning continuation of coverage to the extent not preempted by federal law.

12.9 **HIPAA.** The Group Dental Benefits shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract.

ARTICLE XIII.
GROUP TERM LIFE BENEFITS AND/OR GROUP ACCIDENTAL DEATH & DISMEMBERMENT ("AD&D") BENEFITS

13.1 **Purpose**. The purpose of this Article is to provide for the pre-tax payment opportunity for Group Term Life Benefits and/or Group Accidental Death & Dismemberment ("AD&D") Benefits under this Plan as an Optional Benefit. The Employer provides Group Term Life Benefits and/or Group AD&D Benefits through one or more "plans" within the meaning of Sections 79, 105, and 106 of the Code.

Note: This Article does not permit pre-tax payment of Insurance Premiums for coverage other than for a Participant (e.g., no spousal or dependent coverage).

13.2 **Separate Written Plan**. For purposes of Sections 79, 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

13.3 **Definitions**.

(a) **Group AD&D Benefits** means the accidental death and dismemberment insurance coverage made available by the Employer through this Article to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(b) **Group Term Life Benefits** means the group term life insurance coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual Insurance Contracts.

(c) **Insurance Contract** means any insurance contract secured from an insurance company authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing benefits under this portion of the Plan.

(d) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for group coverage under the Insurance Contract(s).

13.4 **Terms, Conditions and Limitations**. The Employer shall secure the necessary Insurance Contracts Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts or agreements are expressly incorporated into and made part of this Plan.

13.5 **Payments**. The Plan Administrator shall make Insurance Premium payments for the Group Term Life Benefits and/or Group AD&D Benefits on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.

13.6 **Nondiscrimination**. To the extent this portion of the Plan is subject to Section 79(d) of the Code, it shall not discriminate in favor of Key Employees as to eligibility to participate or benefits. If the Plan Administrator determines that the Plan is or may be discriminatory, the Plan

Administrator may take any action permitted by law to avoid such result as described in Section 6.16. If this portion of the Plan fails any applicable nondiscrimination requirements, Key Employees shall have taxable income imputed to the extent permitted by law.

13.7 **Limitation on Group Term Life Benefits**. The cost of Group Term Life Benefits on the Participant's life paid by the Employer shall not be included in the Participant's gross income to the extent the face amount of the Insurance Contract(s) does not exceed $50,000 except as provided in Section 13.6. If the face amount of the Insurance Contract(s) paid by the Employer exceeds $50,000, the cost of the coverage in excess of $50,000 shall be imputed to the Participant as income in accordance with Section 79 of the Code and the Cafeteria Plan Regulations. For purposes of this limitation, coverage paid by the Participant on a pre-tax basis is considered "paid by the Employer." Under no circumstances shall the coverage on the life of persons covered through the Participant be paid through this Plan.

13.8 **Tax Consequences of AD&D Benefits**. It is intended that the Insurance Premiums paid by the Employer (including pre-tax payments paid by the Participant through this portion of the Plan) for a Participant's Group AD&D Benefits shall be excluded in the Participant's gross income under Section 106 of the Code. Any benefits received as a result of the Insurance Contract under this portion of the Plan shall be included in the recipient's gross income to the extent required under the applicable provision(s) of the Code.

13.9 **Continuation/Conversion of Coverage**. There shall be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state laws are not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the Insurance Contract(s) through which benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

ARTICLE XIV.
INDIVIDUAL PREMIUM FEATURE

14.1 **Purpose**. The purpose of this Article is to provide for the pre-tax payment opportunity for certain individual Insurance Premiums under this Plan as an Optional Benefit.

14.2 **Separate Written Plan**. For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the reimbursement or direct payment of individual Insurance Premium expenses. To the extent necessary, other provisions of the Plan are incorporated by reference.

14.3 **Definitions**.

(a) **Claims Run-Out Period** means the period beginning on the first day following the close of the Plan Year and ending on the date specified in the Adoption Agreement.

(b) **Dependent** means, unless indicated otherwise in the Adoption Agreement, a Tax Dependent.

(c) **HMO** means a health maintenance organization.

(d) **Individual Premium Account** ("**IP Account**") means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

(e) **Individual Premium Feature** means this Article of the Plan that permits pre-tax payment of the cost of certain coverage issued on a non-group, individual basis.

(f) **Insurance Contract** means, unless otherwise specified in the Adoption Agreement, an insurance contract secured from an insurance company or HMO authorized to do business in the state in which such insurance contract is issued that has been individually obtained by a Participant. For purposes of this Article, Insurance Contract coverage only includes coverage issued on a non-group, individual basis to the extent permitted under law. Notwithstanding the foregoing, "specialty" coverages (e.g., cancer, vision, hospital indemnity, transplant, dental) are specifically included, unless otherwise specified in the Adoption Agreement. Notwithstanding the foregoing, Medicare Part B, Medicare Part D, Medicare supplement coverages and individual coverage issued through a public insurance exchange are specifically excluded.

(g) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract.

14.4 **Terms, Conditions, and Limitations**. The Participant shall secure the necessary Insurance Contract. Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contract. The Insurance Contract may provide coverage to the Participant's Spouse and Dependents, in addition to the Participant. To the extent a Dependent is provided coverage and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.2. The Insurance Contract may not by its terms violate the requirements applicable to cafeteria plans under Section 125 of the Code including but not limited to operating to defer compensation.

14.5 **Individual Premium Account**. The IP Account will be credited as of each date contributions are made pursuant to Article IV with an amount equal to the allocation, if any, which the

Participant has elected. A Participant's IP Account will be decreased from time to time in the amount of payments made to, or on behalf of, the Participant for eligible Insurance Premiums.

14.6 **Payments**. Claim payments under the Individual Premium Feature shall be administered by the Plan Administrator and/or the Claims Administrator as specified in the Adoption Agreement. The Plan Administrator and/or Claims Administrator shall, as specified in the Adoption Agreement, either:

(a) directly pay the issuer of the Insurance Contract; or

(b) reimburse the Participant following the Participant's payment to the issuer of the Insurance Contract.

Where the Individual Premium Feature does not pay the issuer directly, the Participant must submit a claim for reimbursement including the information described in Section 6.8. Benefits shall be determined in accordance with Section 6.9.

Payments (or reimbursements) shall also be made on behalf of the Participant's Spouse and Dependents, if the Participant has elected to have them covered under this portion of the Plan and they are eligible for coverage under the applicable Insurance Contracts. Such payments (or reimbursements) shall be made from Employer Contributions and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Individual Premium Feature. Under no circumstances will Insurance Premiums payments (or reimbursements) be made with Employer Contributions or other contributions from one Plan Year for coverage actually received in a different Plan Year.

In no case shall a payment be made which exceeds the balance in the Participant's IP Account at the time reimbursement is processed. Claims for reimbursement within a Plan Year must be submitted prior to the close of the Claims Run-Out Period for such Plan Year.

14.7 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan during a Plan Year, no further contributions will be credited to the IP Account. A Participant's right to obtain reimbursements after participation has terminated shall be as provided in the Adoption Agreement.

14.8 **IP Account Forfeiture**. Amounts attributed to a Participant's IP Account for any Plan Year shall be used only to reimburse the Participant for eligible Insurance Premiums incurred during such Plan Year. Any balance remaining in a Participant's IP Account for a Plan Year shall be forfeited following the Claims Run-Out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

14.9 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under the Individual Premium Feature to the extent required by applicable law.

14.10 **Tax Consequences of the Individual Premium Feature**. It is intended that the Insurance Premiums (including pre-tax payments paid by the Participant through this portion of the Plan) for a Participant's Insurance Contract shall be excluded from the Participant's gross income under Section 106 of the Code. Any benefits received as a result of the Insurance Contract under this portion of the Plan shall be excluded from the recipient's gross income to the extent permitted under Section 105(b) of the Code. With respect to coverage that covers a Dependent other than

the Participant's Spouse or Tax Dependent, it is intended that (a) that the coverage for that Dependent be purchased on an after-tax basis as provided in Section 4.2, and (b) the value of any benefits received as a result of such coverage under the Individual Premium Feature be excluded from the recipient's gross income to the extent permitted under Section 104(a)(3) of the Code.

14.11 **HIPAA.** The Insurance Contracts shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract.

ARTICLE XV.
HSA CONTRIBUTION FEATURE

15.1 **Purpose**. The purpose of this Article is to provide for the pre-tax funding of an HSA under this Plan as an Optional Benefit.

15.2 **Separate Written Plan**. For purposes of Section 223 of the Code, this Article shall constitute a separate written plan. To the extent necessary, other provisions of the Plan are incorporated by reference. This HSA Contribution Feature and the underlying HSAs are not subject to ERISA.

15.3 **Definitions**.

(a) **Certification of HSA Eligibility** means the form provided by the Plan Administrator in which the Participant certifies he or she is eligible for HSA contributions.

(b) **HSA** means a health savings accounts under Section 223 of the Code established and owned by a Participant to which contributions are made under this portion of the Plan. The Employer does not sponsor a Participant's HSA, and a Participant's HSA is not an employer-sponsored group health plan.

(c) **HSA Contribution Feature** means the portion of the Plan described in this Article, which consists of contributions to a Participant's HSA through salary reduction and Employer Contributions, if any.

(d) **High Deductible Health Plan** means, unless otherwise specified in the Adoption Agreement, a "qualified high deductible health plan" under Section 223(c)(2) of the Code sponsored by the Employer.

(e) **Permitted Insurance or Permitted Coverage** means:

(1) insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(2) insurance for specified disease or illness (e.g., cancer insurance);

(3) insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance);

(4) coverage for accidents, disability, dental care, vision care, preventive care, or long-term care;

(5) some medical reimbursement accounts and health reimbursement arrangements ("HRAs") (e.g., limited scope medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs); and

(6) some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventive medical care or treatment).

15.4 **Eligibility.** To be eligible for HSA contributions, the Employee must:

(a) be eligible to participate in this Plan under Section 3.1;

(b) be covered by the High Deductible Health Plan;

(c) not be claimed as another person's dependent for purposes of such person's federal income tax return;

(d) not be actually covered by Medicare; and

(e) not have any health coverage other than Permitted Insurance, Permitted Coverage, or coverage under a high deductible health plan (as defined under Section 223(c)(2) of the Code), whether or not such coverage is sponsored by the Employer.

15.5 **Special Enrollment Rules.** Notwithstanding anything in this Plan to the contrary, in order to receive HSA contributions, at the time of enrollment, the Participant must provide to the Plan Administrator a Certification of HSA Eligibility if required by the Plan Administrator. Thereafter, such certification may be requested periodically by the Plan Administrator.

15.6 **Contributions**.

(a) **Employer Contributions**. Employer Contributions, if any, will be contributed to the Participant's HSA at the times established by the Employer.

(b) **Employee Contributions**. Amounts withheld from a Participant's Compensation pursuant to an agreement authorizing salary reduction with respect to this Optional Benefit shall be contributed to the Participant's HSA as soon as administratively feasible.

15.7 **Limits on Contributions**. Contributions made by a Participant and/or on a Participant's behalf (i.e., Employer Contributions) into the HSA under this Plan are limited in accordance with the following rules.

(a) **General Limit.** During a taxable year, total contributions to all health savings account owned by a Participant cannot exceed the statutory indexed amount applicable under Code § 223.

(b) **Catch Up Contributions.** An additional "catch-up" amount (determined on a monthly basis) can be contributed for eligible individuals who attain age 55 before the close of the taxable year.

(c) **Pro-rated Limit if Not Eligible on December 1st.** If a Participant is eligible for HSA contributions during a taxable year but ceases to be eligible prior to December 1st of that taxable year, the contribution limit for that taxable year shall be determined by multiplying 1/12 of the applicable limit by the number of months the first day of which the Participant was eligible for HSA contributions. This pro-rated limit shall apply to all contributions made during the applicable taxable year, including those contributions made prior to the date on which the Participant ceased to be eligible for HSA contributions.

(d) **Special Rule if Eligible on December 1st.** If a Participant becomes eligible for HSA contributions during the taxable year and is eligible on December 1st of such year, the Participant shall be deemed to have been eligible for each month in such taxable year and may make or receive HSA contributions up to the full annual limit. This special rule applies to all contributions made during the applicable taxable year, including contributions made prior to or after December 1st.

Example: An Eligible Employee becomes eligible for HSA contributions on July 1st and remains eligible through December 1st. The Eligible Employee may begin making contributions to his or her HSA through this Plan on July 1st at a rate pursuant to which the full annual contribution will have been made by the end of the taxable year.

If a Participant to whom this special rule applies ceases to be eligible for HSA contributions within the twelve (12) month period beginning with the last month of such taxable year other than by reason of death or disability (as described in Section 72(m)(7) of the Code), then any contribution made in excess of the annual limit under the general rule described above will be included in the Participant's gross income and will be subject to an excise tax as provided in Section 223(b)(8)(B) of the Code.

(e) **Special Rule for Married Participants.** If the Participant is married and both the Participant and Participant's Spouse have coverage under a high deductible health plan (as defined in Section 223 of the Code), the applicable limit is divided equally between them (unless they agree to a different allocation).

(f) **Rollover Contributions.** Rollover contributions may also be made to the HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above.

(g) **Treatment of Excess Contributions.** To the extent total contributions to a Participant's health savings accounts made during the taxable year exceed the applicable limit on such contributions, then the contributions in excess of the limit shall be included in the Participant's gross income and shall be subject to an excise tax as provided in Section 4973(g) of the Code, unless returned in accordance with Section 223(f)(3) of the Code.

15.8 **Investment of HSA Funds.** A Participant may invest his or her HSA funds as allowed by the HSA trustee/custodian. The Employer shall have no control or responsibility for how a Participant's HSA funds are invested

15.9 **Tax Consequences**. It is intended that the HSA contributions made under this Plan shall not be excluded from the Participant's gross income under Section 223 of the Code.

15.10 **Distribution of HSA Funds.** The Employer shall have no responsibility or control over distributions made from a Participant's HSA. The Employer shall have no responsibility to substantiate expenses for which such distributions are made. Sections 6.8 and 6.9 of this Plan shall not apply to distributions from a Participant's HSA. A Participant need not be a Participant in this Plan, be covered by a High Deductible Health Plan of this Employer, nor be covered by any other high deductible health plan in order to receive a distribution from the Participant's HSA.

15.11 **Reporting.** The Employer shall be responsible for reporting contributions made to a Participant's HSA through this Plan on the Participant's Form W-2. Participants shall be responsible for reporting contributions to their HSAs and distributions from their HSAs on appropriate forms. Participants shall also be responsible for determining whether an HSA distribution is taxable.

15.12 **Continuation of Coverage**. This HSA Contribution Feature and the underlying HSAs are not group health plans for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, ("COBRA"), as amended, and reflected in the Public Health Services Act ("PHSA"), as amended, the Family and Medical Leave Act ("FMLA"), and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature and the underlying HSAs.

ARTICLE XVI.
LIMITED SCOPE MEDICAL EXPENSE REIMBURSEMENT PLAN

16.1 **Purpose**. The purpose of this Article is to provide Participants with the opportunity to be reimbursed for certain eligible Limited Scope Medical Expenses as an Optional Benefit under the Plan. This Article is intended to qualify as a medical reimbursement plan under Section 105 of the Code so that payments received under this portion of the Plan are excludable from the gross income of the Participant under Section 105(b) of the Code. This Article is also intended to be "permitted coverage" for purposes of determining eligibility for health savings account contributions under Section 223 of the Code.

16.2 **Separate Written Plan**. For purposes of Section 105 of the Code, this Article shall constitute a separate written plan providing for the reimbursement of Limited Scope Medical Expenses. This is a separate and distinct "plan" from the Medical Expense Reimbursement Plan described under Article XI. To the extent necessary, other provisions of the Plan are incorporated by reference.

16.3 **Definitions**.

(a) **Claims Run-Out Period** means the period beginning on the first day following the close of the Plan Year and ending on the date specified in the Adoption Agreement.

(b) **Dependent** means, unless otherwise specified in the Adoption Agreement, a Tax Dependent.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Limited Scope Medical Expense Account ("Limited Scope ME Account")** means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

(e) **Limited Scope Medical Expense** means an expense identified in the Adoption Agreement that is incurred during the applicable Plan Year by a Participant or by the Spouse or Dependent of a Participant and that qualifies as "medical care" as defined in Section 213(d) of the Code, excluding premiums for health coverage and long-term care coverage. However, if a Participant is covered under a "qualifying high deductible health plan" (as defined under Section 223(c)(2) of the Code) Limited Scope Medical Expense does not include expenses for dental and vision care of the type covered under the qualifying high deductible health plan. If "Limited Scope Medical Expense" includes over-the-counter drugs and medicines, such expenses shall constitute Limited Scope Medical Expenses only to the extent allowed by Section 106(f) of the Code.

(f) **Minimum Annual Deductible** means the applicable minimum annual deductible for a high deductible health plan under Section 223(c)(2)(A)(i) of the Code. If the Participant and/or the Participant's Spouse or Dependent has something other than single coverage under the high deductible health plan, then the minimum annual deductible provided under Code Section 223(c)(2)(A)(i) for family coverage applies; if neither the Participant nor the Participant's Spouse or Dependents has something other than single coverage under the high deductible health plan, then the minimum annual deductible provided under Code Section 223(c)(2)(A)(i) for single coverage applies.

(g) **Post-Deductible Expense** means an expense that is (1) incurred during the applicable Plan Year by a Participant, Spouse, or Dependent; (2) is for medical care as defined in Section 213 of the Code, excluding premiums for health coverage and long-term care

coverage, and (3) is incurred after the Minimum Annual Deductible has been satisfied by the Participant and, if applicable, the Participant's family.

16.4 **Limited Scope Medical Expense Account**. The Limited Scope ME Account will be credited with the amount elected by the Participant and the amount of the carryover, if any, at the beginning of the Plan Year. A Participant's Limited Scope ME Account will be decreased from time to time in the amount of payments made to the Participant for eligible Limited Scope Medical Expenses incurred during the Plan Year and Claims Grace Period, if applicable.

16.5 **Claims Determination**. Claim submission, determination, and appeals shall be handled in accordance with Article VI.

16.6 **Incurred Expenses**. To be reimbursable, an eligible Limited Scope Medical Expense must have been incurred after participation in this portion of the Plan began and during the Plan Year for which reimbursement is claimed or the Claims Grace Period related to such Plan Year, if applicable. An expense is "incurred" when the Participant is provided with the care which gives rise to the eligible Limited Scope Medical Expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses. Notwithstanding the foregoing, pursuant to and in accordance with the Cafeteria Plan Regulations, the Plan may reimburse expenses for orthodontia care in advance.

16.7 **Reimbursement of Expense**. The Participant shall be reimbursed as specified in Section 6.8 from the Participant's Limited Scope ME Account for eligible Limited Scope Medical Expenses incurred during the applicable Plan Year, and the Claims Grace Period, if applicable, for which the Participant submits the documentation required under Article VI. An amount up to the sum of the Participant's Election and the carryover, if any, and reduced as of any particular time for prior reimbursements for the same Plan Year, shall be available for reimbursement at all times during the Plan Year, and the Claims Grace Period, if applicable. Claims for reimbursement within a Plan Year, and the Claims Grace Period, if applicable, must be submitted prior to the close of the Claims Run-Out Period for such Plan Year.

In no case shall a payment be made which exceeds the balance in the Participant's Limited Scope ME Account at the time reimbursement is processed. If a claim for reimbursement exceeds the balance in the Participant's Limited Scope ME Account, the excess part of the claim will be denied. Except as provided in Section 11.12(b), under no circumstances (a) will any balance remaining in a Participant's Limited Scope ME Account at the end of the Plan Year, and the Claims Grace Period, if applicable, be carried over to the next Plan Year, or (b) will an otherwise eligible Limited Scope Medical Expense be carried over to the next Plan Year.

NOTE: In accordance with IRS Notice 2002-45, if the Employer sponsors a health reimbursement arrangement ("HRA") plan, a Limited Scope Medical Expense that is also reimbursable under the HRA plan must typically be reimbursed first from the HRA plan. However, if the HRA provides that it does not reimburse such expenses until the Participant's Limited Scope ME Account is exhausted (i.e., that it is secondary to the Limited Scope Medical Expense Reimbursement Plan), then an eligible Limited Scope Medical Expense may be reimbursed from the Participant's Limited Scope ME Account prior to exhaustion of the Participant's HRA account. In either case, once the Participant's account balance under the primary plan has been exhausted, then the eligible Limited Scope Medical Expense, or any portion of the eligible Limited Scope Medical Expense that has not been reimbursed by the primary plan, may be reimbursed by the other plan.

16.8 **Maximum Reimbursement.** The maximum reimbursement a Participant may receive for a Plan Year under this portion of the Plan shall be the amount indicated in the Adoption Agreement. The maximum reimbursement amount applies to the Participant, Spouse, and

Dependent children on an aggregate basis, not an individual basis. For Plan Years that are less than 12 months, unless indicated otherwise in the Adoption Agreement, this maximum shall be pro-rated by multiplying the applicable maximum by a fraction with a numerator of the number of months in the short Plan Year and with a denominator of 12. For Participants beginning participation in the Plan mid-Plan Year, unless indicated otherwise in the Adoption Agreement, this maximum shall be pro-rated by multiplying the applicable maximum by a fraction with a numerator of the number of months remaining in the Plan Year at the time the Participant begins participation and with a denominator of 12. Notwithstanding the foregoing, salary reduction contributions to this portion of the Plan shall not exceed any maximum imposed under applicable law.

16.9 **Reimbursement Upon Termination of Participation**. If an individual ceases to be a Participant in this portion of the Plan, coverage shall cease (which means that reimbursements shall cease) unless benefits under the Plan are continued as provided in Section 16.14. A Participant's right to obtain reimbursements after participation has terminated shall be as provided in the Adoption Agreement.

16.10 **Participant's Death**. In the event a Participant dies having incurred an eligible Limited Scope Medical Expense (a) which would have been reimbursable out of the Participant's Limited Scope ME Account had the Participant not died, and (b) for which a person or the Participant's estate has paid for or assumed liability for the expense, reimbursement may be made to that person or the estate for that payment or assumption. The remainder of the Participant's Limited Scope ME Account shall be forfeited in accordance with Section 5.7.

16.11 **Nondiscrimination**. This portion of the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such result. If the Plan fails any applicable nondiscrimination requirements, Highly Compensated Individuals shall have taxable income imputed to the extent required by law.

16.12 **Limited Scope ME Account Forfeiture**.

(a) **Limited Scope ME Claims Grace Period**. If selected in the Adoption Agreement, the Claims Grace Period shall apply to this Optional Benefit.

(b) **Limited Scope ME Account Carryover.** If selected in the Adoption Agreement, a limited carryover of Limited Scope ME Account balances from Plan Year to Plan Year will be provided in accordance with the following conditions and restrictions:

(1) The amount that may be carried over is limited to the lesser of (i) the amount specified in the Adoption Agreement, or (ii) the balance of the Participant's Limited Scope ME Account. The balance of a Participant's Limited Scope ME Account shall be determined upon expiration of the Claims Run-out Period.

(2) Notwithstanding the requirement referenced in paragraphs (1) above, the balance of the Participant's Limited Scope ME Account as of midnight on the last day of the Plan Year, up to the amount specified in paragraph (1) above, shall be carried over and available to reimburse Limited Scope Medical Expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the Claim Run-out Period (including allocating claims between the Participant's carryover balance and the Participant's election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

(3) In general, a carryover made in accordance herewith shall occur automatically. However, a Participant entitled to a Limited Scope ME Account carryover in accordance herewith may elect, by no later than the last day of the Plan Year from which the carryover is to be made and in accordance with procedures adopted by the Plan Administrator, to waive the carryover.

(4) Unless otherwise required under applicable law (including regulatory guidance), a carryover of a Limited Scope ME Account balance shall be available only to individuals who are eligible to make elections under the Limited Scope Medical Expense Reimbursement Plan as of the first day of the Plan Year to which the carryover will be made (regardless of whether the individual actually elects to participate).

(c) **Limited Scope ME Account Claims Run-Out Period**. Except as otherwise provided herein (1) amounts attributed to a Participant's Limited Scope ME Account for any Plan Year shall be used only to reimburse the Participant for eligible Limited Scope Medical Expenses incurred during such Plan Year, and (2) any balance remaining in a Participant's Limited Scope ME Account for a Plan Year shall be forfeited following the end of Claims Run-Out Period and shall be forfeited in accordance with Section 5.7. The Plan Administrator may extend this period in the event the Participant cannot obtain proper documentation until after the expiration of the period. Such forfeited amount shall not be distributed in cash, carried over to the next Plan Year or used by the Participant for any other purpose.

16.13 **Medical Child Support Orders**. Notwithstanding any provision of this Plan to the contrary, this Plan shall recognize child support orders regarding coverage under this Limited Scope Medical Expense Reimbursement Plan to the extent required by applicable law.

16.14 **Continuation of Coverage**. Continued coverage shall be provided under this Limited Scope Medical Expense Reimbursement Plan as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference.

16.15 **HIPAA**. The Limited Scope Medical Expense Reimbursement Plan shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in Article XVIII.

16.16 **Further Limitations on Benefits**.

(a) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are payable under any worker's compensation law or other employer, union, association or governmental sponsored group insurance plan.

(b) This Article does not cover expenses incurred for any loss caused by or resulting from injury or disease for which benefits are received by the Participant, the Participant's Spouse or the Participant's Dependent under any health and accident insurance policy or program, whether or not premiums are paid by the Employer or the Participant, the Participant's Spouse or the Participant's Dependent child.

(c) Amounts reimbursed under a dependent care assistance program described in Section 129 of the Code shall not be reimbursed under this Plan.

(d) Other limitations, if any, shall be set forth in the Adoption Agreement.

16.17 **Patient Protection and Affordable Care Act.** The Limited Scope Medical Expense Reimbursement Plan is intended to be an excepted benefit under HIPAA because either:

(a) it provides only dental and vision benefits; or

(b) it satisfies both of the following conditions:

(1) all Participants of this Optional Benefit are eligible for Group Medical Benefits, and

(2) the maximum reimbursement available does not exceed the greater of (i) two times the Participant's salary reduction election or (ii) the Participant's salary reduction election plus $500.

Accordingly, certain mandates of the Patient Protection and Affordable Care Act, as amended, including the preventative care mandate, do not apply to the Limited Scope Medical Expense Reimbursement Plan.

ARTICLE XVII.
CASH PAYMENT

17.1 **Purpose**. The purpose of this Article is to describe the Cash Payment available under this Plan as an Optional Benefit. Any portion of the Employer Contribution that is not allocated for the purposes of benefits under this Plan may be available to the Participant in cash.

17.2 **Terms, Conditions and Limitations**. A Participant is entitled to allocate the Employer Contribution to pay for Optional Benefits. To the extent a Participant does not allocate all of the Employer Contributions to other Optional Benefits available under this Plan, a Participant shall receive a Cash Payment equal to the amount of the unallocated Employer Contribution, subject to any restrictions specified in the Adoption Agreement.

17.3 **Payment**. Cash Payments shall be made at least monthly and within the month that the Employer Contribution would otherwise have been allocated for Optional Benefits. Cash Payments shall be made only to Participants. If a Participant ceases to meet the eligibility requirements, then Cash Payments cease.

17.4 **Tax Consequences**. Any Cash Payment received through the Plan is taxable income to the Participant.

ARTICLE XVIII.
HIPAA PROVISIONS

The Privacy Rules and Security Rules under HIPAA apply to certain Optional Benefits of the Plan that constitute "covered entities" within the meaning of HIPAA (e.g., employer sponsored group health plans), unless such Optional Benefits are self-insured and have less than fifty (50) Participants and the Employer is the Claims Administrator for such Optional Benefits. Such Optional Benefits are referred to in this Article XVIII as the "Plan."

18.1 **Use and Disclosure of PHI**. The Plan will use PHI to the extent allowed by, and in accordance with the uses and disclosures permitted by, HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Employer in accordance with this Article XVIII, the Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

(2) coordination of benefits;

(3) adjudication of health benefits claims (including appeals and other payment disputes);

(4) subrogation of health benefit claims;

(5) establishing employee contributions;

(6) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) billing, collection activities, and related health care data processing;

(8) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan); and

(13) reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) quality assessment;

(2) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) business management and general administration activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) customer service, including data analyses for policyholders.

(8) resolution of internal grievances; and

(9) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

18.2 **Employer's Obligations under the Privacy Rules**. Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received for the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

18.3 **Employer's Obligations under Security Rules**. If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) report to the Plan any Security Incident of which it becomes aware; and

(d) implement reasonable and appropriate security measures to ensure that only those persons identified below have access to ePHI and that such access is limited to the purposes identified below.

18.4 **Adequate separation between the Plan and the Employer must be maintained**. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) the person employed in the position that is given primary responsibility for performing the Employer's duties as the Plan Administrator of the Optional Benefits; and

(b) staff designated by the person described in (a) above.

18.5 **Limitation of PHI Access and Disclosure**. The person(s) described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.

18.6 **Noncompliance Issues**. If the person(s) described above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.